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EXCESSIVE HÆMORRHAGE AFTER CATARACT EXTRACTION.

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Such cases like that reported by Dr. Fryer in the last number of this journal, are fortunately very uncommon indeed; and very little must have been published about so grave an accident as the occurrence of profuse and disastrous intra-ocular hæmorrhage after cataract extraction. For otherwise I cannot understand why the text-books are so surprisingly silent about it; even the large handbook edited by Graefe and Saemisch does not mention it, though it gives elaborate descriptions of the operations and enumerates the accidents which possibly may occur during and after the operation. This is surely very strange, for among all the accidents we can scarcely imagine any one more shocking than this one, and it is the more exasperating because it usually occurs after a regular smooth operation when we least anticipate any trouble. At least in all cases which have come to my knowledge the operation has been normal and the immediate test of vision satisfactory.

I had no personal experience of this kind until last fall when I lost two cases by this terrible accident.

The first case was a patient aged 54, in the Illinois Eye and Ear Infirmary. Mature cataract in left eye; Graefe's operation was performed under cocaine and sublimate August 21, at 2 p. m.; extraction normal in every respect; pupil clear and black; patient could count fingers readily after the operation. About 9 p. m. he had a violent attack of vomiting and diarrhœa followed by severe pain in the eye and head and oozing of blood through the bandage. The house-surgeon renewed the dressing several times during the night, but when I saw the patient in the morning the bandage was again thoroughly saturated with blood; and on removing it I found the whole vitreous streaked with blood outside of the wound. In spite of moderate pressure bandage the bleeding continued the whole day. A mild form of panophthalmitis supervened and atrophy of the globe closed the drama.

The second case occurred in private practice. The patient with mature cataract of both eyes was a fleshy, stout lady of 66 years, much inclined to congestive flushing of the face.

Oct. 19, at 2 p. m., operation on the right eye; incision along the upper border of the transparent cornea; delivery of the cataract very easy and perfect; patient recognized at once her daughter and friends and counted my fingers easily. She went directly to bed and was perfectly comfortable when I visited her at 7 o'clock. But at 9 p. m. she was suddenly seized with violent pain in the eye and right side of the head, followed by nausea (but she did not vomit) and blood oozing through the bandage. On removing the dressing the wound was found widely open, the vitreous protruding, and the blood flowing in a continuous current. The hæmorrhage lasted all day; the whole vitreous was expelled; and after a long siege of inflammation the eye became slightly atrophic with the cornea transparent, and the anterior chamber restored, but the posterior cavity of the globe filled with a fibrinous mass.

The similarity of these two cases with Dr. Fryer's would be complete but for one point, to-wit, he does not mention the escape of the vitreous body. But could that not have come away with bloodclots and thus have escaped the doctor's

notice? It certainly does not seem at all probable that this excessive hæmorrhage should have come from the stump of the iris as the doctor thinks. It would be difficult to understand how a hæmorrhage from this source could induce the rapid degeneration of eye with all the characteristic signs of diffuse choroiditis. It is more likely that in his case, like in mine (and in those of Dr. Mooren I shall presently mention, the bleeding started behind the vitreous in the retina or choroid (probably, the latter) and caused the detachment and expulsion of the whole vitreous.

It may be interesting in this connection to state the observations of the ophthalmic surgeon than whom very few have a greater experience in cataract operations. In his excellent résumé of twenty-five years of ophthalmic practice Dr. Albert Mooren says that in 2,872 cases of extraction he met but three times with this uncommon accident of disastrous intra-ocular hæmorrhage. "I made the first experience of this kind ten years ago with the eye of an old Spanish gentleman. The extraction of the cataract was perfectly normal, and I was just putting on the bandage, when suddenly the patient was seized with the most violent pain in the temples, followed by vomiting and blood appearing through and from under the bandage. Upon removing the bandage I found the entire vitreous body had escaped; and in spite of pressure bandage the blood continued to pour forth from the eyeball for 10 or 12 minutes. After the coagulated blood was removed the edges of the wound re-united, and the eyeball was preserved, but the whole choroid was detached.

The second case was an asthmatic lady. On account of her condition preliminary iridectomy was performed on both eyes; and 18 days later the cataract was extracted from the left eye. It was a perfectly smooth operation and the patient had been in bed 15 minutes, when suddenly her face became flushed and the left temporal artery was pulsating so violently that it was noticed by everyone around the patient. This was followed by violent temporal neuralgia and vomiting, and one minute later blood was seen oozing from under the bandage.

When this was removed the whole vitreous was expelled from between the eyelids followed by a profuse gush of blood. The pain ceased soon afterwards; but the bleeding continued five days.

About three weeks later the operation was done upon the other eye. The operating table was placed so that the patient could be lifted from it directly into her bed. Again the operation was perfect in every respect; but 15 minutes later the same redness of the face, the same temporal neuralgia with vomiting, hæmorrhage and expulsion of the vitreous. Both eyes became atrophied.

I know of no diagnostic means by which we could predict the occurrence of this awful catastrophe. The only sign indicating the possible morbid condition of the arterial walls, is an unusual tortuosity and rigidity of the temporal arteries, though their condition is far from furnishing any positive indication that this terrible catastrophe is likely to occur. As it is, we must content ourselves with saying these accidents speak very strongly for Dr. Michel's opinion of the intimate relation existing between the formation of cataract and arterial sclerosis; for I have no doubt that the escape of the vitreous in these cases is caused by an intra-ocular hæmorrhage occurring at a moment when (after the extraction) the blood pressure within the arteries is not sufficiently counter-balanced by the pressure of the contents of the globe." (*Fünf Lustren ophthalmologischer Wirksamkeit, von Dr. Albert Mooren, 1882.*)

ATYPICAL ALCOHOLIC NEURITIS.

BY H. GIFFORD, M. D., OMAHA, NEB.

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Under the title "*Pseudo-Atrophies de la Papille*," Trousseau¹ has reported four cases of toxic amblyopia, three from alcohol and one from tobacco, in which, instead of typical atrophy of the outer half or quadrant of the disc, the whole papilla seemed atrophic. In one of these there was no central scotoma, but a decided contraction of the field; and this, with the occurrence of other tabetic symptoms, made the prognosis most grave. Nevertheless, in this as in other cases abstinence and strychnia caused a marked and permanent improvement in the sight and, in three of these cases, the papilla regained its normal aspect.

The following is a similarly exceptional case:

Sept. 21, 1886, S. B., æt. 58, middle-sized man of fair vigor. More than a year ago sunlight began to dazzle his eyes more than usual. Soon after, noticed cloud in the centre of left field. This has been getting denser since. About a year after affection of L. E. noticed similar cloud before R. E. For six years has used alcohol and tobacco to excess. No history of syphilis. Stat. præs. Pupils very small; that of L. E. smaller. Contraction of pupils to light or accommodation so slight as to be doubtful. Media clear, whole papilla in each eye slightly, though distinctly atrophic; more so in L. E.—R. E. $V=\frac{2}{1}+$, excentric. Glasses = 0. Oval scotoma at centre of field from 5° at nasal side to 10° at temporal side. At centre scotoma is absolute, toward margins, white is recognized but colors not. Outer limits of field normal for white, no note

Trousseau; Bull. de la Chir. Oph. de l'hosp. des Quinze-Vingt, V. 1, p. 45.

of color field. L.E. $V=2/_{1xx}$. Field as in R.E. except that scotoma extends to 15° at the temporal side. A month or so ago had slight paresis of left side of mouth and of thumb and forefinger of left hand, with lameness of left radial muscles; paresis better now but still evident; knee-jerk very much reduced. Stands well with eyes closed. Has darting "rheumatic" pains but no worse than for years. Ord. abstinence, galvanism, strychnia. Prognosis, both as to improvement and retention of vision, very dubious, for, in spite of the alcoholism and the typical scotoma, the other symptoms, particularly the general atrophy of the papillæ and the long interval between the dates of the eyes seemed to exclude alcoholic neuritis and make probable the beginning of some general nervous trouble, if not *tabes dorsalis*, perhaps a disseminate sclerosis. October 6, goes East for a time. R.E. $V=2/_{x1}$; L.E. $V=2/_{1}$; scotoma about the same. Used strychnia pills and potassium iodide. Nov. 22, returned on his way home to Oregon. R.E. $V=3/_{xxx}$; L.E. $V=2/_{x1}$. Fundus unchanged. No record of field. Patient has had no difficulty in abstaining: continue strychnia and iodide with intervals of suspension. May 21 1887, reports by letter that sight has slowly but steadily improved till now with his old reading glasses; at ordinary reading distance R.E. reads "No. 1 Diamond" about. L.E. reads "No. 8 Small Pica." Cloud still in centre of left field. Sight much better sometimes than others. Still takes strychnia and potassium iodide at intervals. November 1, 1887, letters from patient and his physician report that sight is still clearer and steadier. Of late has had numbness at base of toes of left foot. Knee-jerk, especially left, still impaired. Pupils still small and nearly or quite immovable on exposure to light. Has maintained abstinence except for the moderate use of port wine (!)

As before mentioned, I was at first inclined to regard this case as one of incipient *tabes*. The impaired knee-jerk, the myosis, the paresis of the radial muscles, to which but a short time before Struempell¹ had called attention as an early symp-

¹Struempell; Berlin Klin. Wochenschr, 1886, 37.

tom of tabes; and the appearance of the discs all pointed in that direction. True, the field was directly opposed to this supposition. Förster¹ says that, in his experience, central scotomata contraindicate tabes; and Schmeichler² in his elaborate paper on the symptoms of tabes, practically pronounces them unheard of as a tabetic complication. Still, others speak of central scotoma as a very rare symptom of tabes, so I did not feel warranted in excluding the latter on this ground alone. However, the results of the abstinence and strychnia have convinced me that the whole trouble was a multiple alcoholic neuritis, though so far as the eyes were concerned, a very exceptional one. The general paleness of the nerve has not, so far as I can learn, been observed by any previous author except Trousseau. The myosis is also a rare feature. Bernhardt³ says that myosis and reflex fixity of the pupil occur in alcoholic tabes rarely or not at all. But the most unique feature of the case is its non-symmetrical developement. In his remarkably exhaustive monograph on the effects of chronic alcoholism on the eye Uthoff⁴ states as one of the differential points between non-toxic retrobulbar neuritis and alcohol and tobacco amblyopia, that in the latter the affection always occurs simultaneously or with only a few day's interval, in both eyes. My patient is positive that there was at least six months and he thinks about a year, between the beginning of the affection in the two eyes. It is not impossible however that a slight scotoma in the second eye might have been overlooked for some time, as the patient was of an extremely easy-going disposition.

The fact that cases like the above and those of Trousseau occur, is of importance not only from their rarity but from a prognostic point of view. By giving broader views of the

¹Förster; Graefe-Saemisch, VI p. 132.

²Schmeichler; Arch. f. Augenheilk., XII p. 458.

³Bernhardt; Ref. in Fortschritte d. Med. 1887, 13.

⁴Uthoff; v. Graefe's Arch. f. Oph. XXXIII, I, p. 310.

scope of alcoholic amblyopia they will occasionally enable us to make a much desired qualification of our prognosis.

FURTHER EXPERIMENTS WITH HYDROCHLORATE OF ERYTHROPHLEINE.

BY ADOLF ALT, M.D.

Since my last communication on experiments with the hydrochlorate of erythrophleine, I have used it in a $\frac{1}{10}\%$ solution in a number of cases with the following results.

This stronger solution acts, it seems, more equally upon the conjunctiva and cornea. The beginning of the anæsthesia can often be felt after one minute, always after two. I stated in my last communication that the cornea does not seem to become as markedly anæsthetic as the conjunctiva. The fact seems to be that, although the feeling of pain in the cornea (as caused, for instance, by the removal of a foreign body) is abolished, the feeling for the touch does not seem to be totally lost. Where there is an ulcerative process in the cornea the pain following the instillation of erythrophleine is enormous, and it can barely be reduced by the free use of cocaine.

In the healthy eye also the instillation of such a stronger solution of erythrophleine causes a very disagreeable amount of pain which seems to become worse, until about half an hour after the instillation, when it gradually subsides. Later on sight appears to be interfered with in most cases and this is due to a slight haziness of the corneal epithelium. Some people also see red and blue colored rings, as in glaucoma, the blue ring being inside of the red one. This I observed especially in older individuals.

I tried to perform a tenotomy on an eye under the influence of erythrophleine, but the patient complained of such pain that I had to resort to cocaine. I have since in several cases first used cocaine and when the eye was anæsthetic instilled erythrophleine, with the idea of prolonging the anæsthesia

and reducing the pain and irritation caused by the erythrophleine.

Without going further into details my experience with erythrophleine leads me to the following conclusions.

Merck's erythrophleinum hydrochloricum has an undoubtedly anæsthetic effect upon the conjunctiva and cornea.

It differs, however, in its action from cocaine.

Even in a weak solution it causes a very large amount of pain and irritation.

Although a diminution of sensibility is felt much quicker than with cocaine, a full anæsthesia with regard to painful manipulation is established considerably later.

The anæsthesia due erythrophleine lasts much longer than that produced by cocaine.

Erythrophleine does not influence the accommodation and has no influence on the sphincter pupillæ, unless it be a slight myosis.

The anæsthetic action of erythrophleine seems to be confined to the place which the solution actually touches. At least, I find, that unless I allow the solution to run over the whole of the cornea, the anæsthesia will remain confined to the lower part of the cornea with the solution will come in contact when instilled into the lower cul-de-sac.

From the foregoing it is, it seems to me, very doubtful whether erythrophleine, whatever advantages it may give to the surgeon in general, will be and can be very advantageously used in ophthalmic practice. So far cocaine is decidedly less disagreeable, and brings about a full and deep anæsthesia in a shorter time, and is, therefore, to be preferred. Where the prolonged duration of the anæsthesia is so much desired, that all other effects from erythrophleine are of less importance, it will be in its place, and its irritating qualities may be somewhat subdued by first putting the eye under full anæsthesia by means of cocaine.

ON THE INFLUENCE OF THE REMOVAL OF
THE PUNCTUM PROXIMUM AND GREATER
CORRECTION WITH CONVEX GLASSES
IN HYPEROPIA.

BY H. CULBERTSON, M. D., ZANESVILLE, OHIO.

Professor Foerster, of Breslau, has published in Vol. XV, page 399, of the *Archives of Ophthalmology*, an article on the influence of concave glasses in retarding the increase of myopia, when proximal objects are observed at about 40 cm. from the bridge of the nose. He aims to employ the lowest concave glass giving distinct remote vision, but does not think it necessary to use concave glasses when the myopia is no greater than $-D\ 1.75$. Soon after reading this paper I began to give full correction for all high grades of myopia and taught my patients to hold objects at 40 cm. from the cornea in vision near at hand. I soon found that this was a decided advantage, and in not a single instance has it been necessary to increase the power of the concave glasses, or discontinue the use of glasses so applied from discomfort attending their employment in near vision.

Having observed this practical result it occurred to me, that the principle of removing objects in proximal vision might be advantageous in hyperopia as well as in myopia, and proceeding thus, that, a fuller correction could be given primarily, without the danger of inducing artificial myopia when the correcting glass was applied in hyperopia. On testing this matter it was found practical. Without entering into a scientific demonstration of this subject, I will simply say that my belief is, that the successful result in these cases is attained by the diminution of accommodation induced by the removal of the

object from the eye, the convex glass performing the office of the ciliary muscle, and by its relaxation asthenopia is diminished and from the remoteness of the object convergence is rendered less.

I found that this plan does best in those whose age endows them with an amplitude of ciliary-muscle-power and in whom the relation of this force to the degree of hyperopia is no longer able to be sustained or compensatory. Full correction may not be given, but a larger per cent can be if the proximal object be removed to 40 cm.

To illustrate—a patient is 20 years of age, with $=D\ 10.$ of accommodation and $D\ 4.$ of hyperopia. Such an one to read at 10 cm. must exercise $D\ 14.$ of accommodation which at this age is not ordinarily possessed, and hence the object must be removed $=D\ 10. - D\ 4. = D\ 6. = 16\text{ cm.}$ But even at this object distance, asthenopia is not relieved and the ciliary muscle is exercising its full force, whereas there should be a *reserve force* in this muscle before rest can be obtained and the evils of over-work obviated in the eye. If now the hyperopia be corrected with $+D\ 4.$ spheric, there will be found $D\ 10.$ of accommodation. We now insist upon the patient reading at 33 cm; or but $D\ 3.$ of accommodation are employed, and there remains, $10 - 3 = D\ 7.$ of accommodation unused. The eye is therefore at rest, convergence diminished and an opportunity given to restore the ciliary muscle to its wonted power, and to relieve the evils of asthenopia by rest. We may not be able to correct all the hyperopia at once in these cases, but if the object is held more distant from the eyes a greater degree of hyperopia can be neutralized, primarily. Such has been my observation.

The application of the convex glass will have a tendency to present that diminution of the object-image upon the retina arising from the proposed removal of the object in proximal vision.

There are then two factors tending to diminish the presence of artificial myopia when convex glasses are applied to correct hyperopia, viz., the natural impulse to relax accommodation,

and the reduction of the ciliary-muscle-force incident to the removal of the object from the eyes.

It may be asked if artificial myopia is induced in hyperopia by the presence of the convex glasses, should not the object be brought closer to the eye, thus giving greater obliquity to the visual rays of light, and hence casting the focus posteriorly upon the retina, why not make this approachment and correct the myopia in this manner? I would answer this, that, so far as I am able to judge, the very act of carrying the object nearer to the eye would increase the accommodation and serve to keep up the artificial myopia, while the removal of the object would naturally tend to diminish the acting force of the ciliary muscle, and therefore the degree of artificial myopia.

I have been using this plan for nearly a year and find it successful. I do not consider it necessary to report all my cases—two will serve as well as fifty, to illustrate this paper.

Mr. J. L. M. aged 18, has latent hyperopia shown by duboisia= $+D_{3.5}$, and with these glasses V. Re= $\frac{4}{x_1}$ Snellen. After the effects of the mydriatic had passed off V. R and L,= $\frac{8}{x_1}D$ and V with both eyes= D^6/x_1 Snellen. These glasses were comfortable.

Miss S. C. B. aged 21, has latent hyperopia= $+D_{.25}$, each eye, developed under duboisia. After the effects of the mydriatic had passed off, these glasses were given and vision became comfortable in each eye and V with both eyes= $\frac{6}{x_1}$ Snellen. Both of these and all my other patients were instructed to place the object at 35 to 40 cm. in near-vision.

AN OPERATION FOR SIMPLE FORMS OF ENTROPIUM.

BY FRANK ALLPORT, M. D.,

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There are at present so many operations for entropium before the profession, that I feel considerable reluctance in placing before its notice yet another.

For several years I have regarded Dr. F. C. Hotz's operation as the best and most rational procedure in use. I have in no wise changed my mind. I still claim superiority for his method when used in all grades of entropium. But I desire to place upon the record, another operation that appears to be equally efficient in a certain grade of cases, and possesses the invaluable quality of extreme simplicity.

It is in reality based upon the same principle as Hotz's method, in that it seeks to obtain union between certain of the soft tissues of the lid and the tip of the tarsal cartilage.

An anæsthetic (general) is not usually required, and as a rule not a drop of blood is evacuated.

A few drops of a 4 per cent solution of cocaine, should be instilled on the conjunctiva until complete local anæsthesia is produced. The instruments required are a broad straight needle, a needle-holder, some strong, coarse black thread that should be doubled before using, a pair of forceps—and a pair of scissors.

By the aid of the needle-holder the needle armed with the double thread, should be inserted into the skin, midway between the internal and external canthus, and just below the upper boundary of the tarsal cartilage. The lid meanwhile should be held away from the eye-ball and slightly downward by means of the forceps, which should grasp the free edge of

the lid, midway between the canthi. The needle should now be forced directly through the lid, on emerging from the conjunctiva, from whence it should be pulled, until about four inches of thread remain on the outside of the lid. The needle should now be inserted into the lid from the conjunctival surface, and forced again directly through the lid. On emerging on the outer side of the lid, it should be pulled, and the suture snipped. The track of the two sutures should be side by side and about two lines apart, as shown in figure 2.

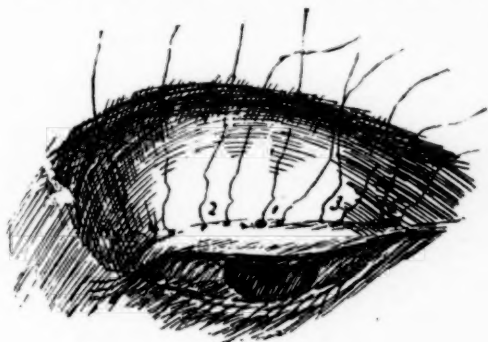


FIG 2.

1. First suture. 2. Second do. 3. Third do. 4. Fourth do. 5. Fifth do.

The loop-suture now includes principally skin, muscle, tip of tarsal cartilage, and conjunctiva. The two ends of the suture should now be tied as tightly and securely as possible, much care being given to this point.

Five sutures like this, should be inserted, and the lid dressed, with vaseline, cotton and a bandage. No effort should be made to subdue the inflammation, unless it be severe, as a certain amount of inflammation at the points of the sutures is necessary to the entire success of the operation. The sutures are allowed to remain for about a week or ten days, unless there should arise contingencies, that would necessitate their removal. By this time it is hoped there will be sufficient adherence between the tip of the tarsal cartilage and the soft tissues anterior to it, to produce a turning out of the lashes.

As is well known it takes but a very small amount of pressure, applied with a probe to the skin overlying the tip of the tarsal cartilage to produce an eversion of the lid margin. This observation is involved in the operation, and in my hands it has been quite successful in thirty-one lids during a period of eight months. I have said "quite successful," for I have tried it in all cases, both mild and severe, and it has not accomplished satisfactory results in severe cases. But in mild and medium entropium, it has given entire satisfaction. It is a simple operation, as will be seen, and does not necessitate general anæsthesia. It is practically bloodless, involves no loss of tissue, no disfigurement, and may be done in the office while the patient sits in a chair. Possessing these qualities and its use being restricted to mild and medium cases, I think it will find a place among useful operations.

THE PERIODICAL INTERNATIONAL CONGRESS OF OPHTHALMOLOGISTS.

Seventh Meeting, Heidelberg, August 9th to 12th, 1888.

The ophthalmological society founded by A. von Graefe decided at the second meeting of its last year's session at Heidelberg, to celebrate its 25th anniversary in the year 1888, by inviting the ophthalmologists of all countries to take part in their session (beginning at the 9th of September 1888) and thus by their presence to change the yearly congress of ophthalmologists at Heidelberg into an International Congress. The necessary work to carry out the intentions of this decision was put into the hands of a committee whose names are signed to this communication.

We were enabled to take this task on our shoulders, as honoring as it is difficult, by the fact, that the ministry of justice, cultus and education of the Grand-Dukedom of Baden and the authorities of the city of Heidelberg had assured us in a most liberal way of their support.

It is therefore to be expected, that, in spite of the limited exterior facilities under which the congress will meet at Heidelberg, and aside from the scientific stimulus undoubtedly offered by a convention of so many excellent scientists, the guests will take away with them impressions of the city and the country of such a peculiar character, that they will not miss in too great a measure the lasting impressions received in cities like Brussels, Paris, London, New York and Milan.

In so bringing to the knowledge of the ophthalmologists and their friends the resolution of the ophthalmological society by means of the press, we think it necessary to enlarge on an important point, before making known the exact programme of the congress.

Can the Ophthalmological Society of Heidelberg call an international meeting, thus invited, the seventh session of the periodical international congress of ophthalmologists?

This question can only be decided by looking back into the history of the origin and the subsequent development of the *Congres International periodique d'ophtalmologie*.

The series of congresses of ophthalmologists began with the meeting at Brussels, September 13th to 16th, 1857. The first instigation was due to Dr. Warlomont, the editor of the *Annales d'oculistique*, which have appeared in Brussels since 1836. President Fallot in his inauguration-address attributes the success of convening the congress especially to him and to the extraordinary good-will of the minister of the interior, De Decker. The names of the vice-presidents which were elected with consideration for the states most numerous represented, show the international character of this congress. They were, James Dixon, Arlt, Melchior (Daenemark), Sichel, Stromeyer, Sperino, Donders, Marques (Spain), von Graefe, von Kabbath (Russia) and Ammon. Secretary was Warlomont. The number of participants was 160.

This meeting at Brussels was in fact the first international congress of ophthalmologists. We have the more right to call it so, since the first session of the *Societe universelle d'ophtalmologie*, chartered by the French government, March 1861, and held in October 1861, can, from a scientific consideration, hardly be called a congress (cf. Ann. d'ocul. XLVI, p. 243).

In the report of the second session of the *Societe universelle* held between the 30th of September and the 3d of October, 1862, Warlomont states, that the first meeting had been visited by a certain number of renowned foreign ophthalmologists (*un certain nombre d'ophtalmologistes etrangers de distinction*), which came as private individuals or as delegates from their respective governments. (Of these there were 15 in all). Further on Warlomont says, that these prominent scientists on their arrival in Paris were not a little astonished to be the only ones, and to find but very few French colleagues at the place of meeting.

After having passed a few days in scientific discussions this meeting recognized it as its nearest and most important task, to reorganize the *Societe universelle d'ophtalmologie* on a new basis.

This was done at a meeting held October 13th 1861, in which the Parisian colleagues took part. It was then decided to meet yearly, not, however, always at Paris, but to change

the place of meeting, although for the ensuing year (1862) Paris was once more chosen. Ten cities lying in different countries were mentioned as being well-fitted to receive the society. Later on the permanent committee residing in Paris added 21 more names to this list.

The constitution, as recommended by the permanent committee at the first meeting of the second session of the *Societe universelle* (1862) was thoroughly discussed and adopted with some changes. The most important resolution was, that the sessions should take place every 4 years, instead of yearly. (The number of participants was 113).

This resolution prompted Warlomont to state, that the *Societe universelle* by adopting this interval of 4 years had changed its original character as a permanent society into a periodical congress. It was, therefore, necessary to adopt the name of *Congres international periodique d'ophtalmologie*. He further correctly added, that the session of 1862 must be considered as the second congress or even as the continuation of the Brussels Congress of 1857. "Too many ties unite this one with the Brussels session of 1857, not to make it appear logical, to view it as a continuation of the work in which so many excellent members of that meeting have already taken an active part."

Thus the Periodical International Congress of Ophthalmologists was founded in fact and in name.

Let us look at its further fate.

For the third meeting in 1866, Vienna was selected. In spite of the advanced state of the preparations made by the Vienna committee, it did not take place. The war prohibited it. The next year, 1867, again insuperable obstacles presented themselves. Therefore, Frederick Jaeger and Arlt handed back their mandates to the permanent committee of the *Societe universelle d'ophtalmologie de Paris*, which, in name at least, was still in existence, feeling confident that an invitation to Paris for the 3d session in 1867 would give general satisfaction, since the universal exposition anyhow drew the scientific world to Paris. The third session, called the second Paris congress, was accordingly opened on the 12th of August in the

Salle du Grand Orient de France with 114 members. Its splendid success, especially brilliant on account of Helmholtz's attendance, is well known.

At the meeting in the forenoon of the 14th of August the year 1871 was decided upon for the fourth session and Berlin as the place of meeting, since Arlt declined decidedly to have it meet at Vienna.

Again the fates of war had not been reckoned with. The death of von Graefe in 1870 made the success of the Berlin congress doubtful, the war impossible.

It was Critchett who at the Heidelberg meeting (Sept. 5th 1871) revived the international congress on his own responsibility. Without being especially delegated to do so, he invited the ophthalmologists present in his name and that of his English colleagues, to convene as an international congress in London in the following year (1872). The time should not be put later than August, since the September weather in London was dismal and dreary.

In his inaugural speech at the meeting of the fourth international periodical congress of ophthalmologists, (Aug. 1, 1872) he especially mentioned, that the reviving influence had come from the preceding meeting at Heidelberg. (The participants numbered 104).

The prominent English ophthalmologists, especially Bowman and Critchett, the world-renowned Moorefields Hospital, the English hospitality and the interesting points of the giant-city, gave to this congress a brilliancy of character, thus far unknown. This meeting further succeeded at its last session on the 3d of August in determining, according to the constitution, the date and locality of the fifth session, which actually took place accordingly.

Prepared by Agnew, Noyes, and Roosa, this congress met at New York, from September 12th to 14th 1876. Although its membership was large (104), but few, as was natural, of the European ophthalmologists had gone across the ocean.

This session thought the continuation of the congress insured by electing on motion of Dr. Noyes, a committee, consisting of Dr. Hansen, of Copenhagen, Drs. Becker, of Heidelberg, and

Arlt, of Vienna, with full powers to select time and place of the next meeting, and to transfer these powers to a local committee after the place should have been decided upon.

In spite of the earnest efforts of this illegally elected committee, it could not succeed in executing its mandate. It could neither gain the consent of the interested parties for Copenhagen, nor for one of the Swiss cities. The ophthalmological section of the universal medical congress, held in Geneva in September 1877, unanimously asked to have the next international congress of ophthalmologists called together at Vienna, in 1880. Arlt had already taken care to secure the liberal support of the Austrian government. But, the whole scheme fell to the ground, when some of the most prominent ophthalmologists of Vienna, refused to act in concert with the wishes of the committee.

The members of the committee, at that time, thought it best not yet to select a city within the new German empire. They were thus forced to announce through the press, that they refused further action in this matter, and transferred their powers into the hands of the ophthalmological section of the medical congress at Amsterdam.

This section accepted the mandate and resolved at a meeting, held September the third, 1879, that the sixth periodical international congress of ophthalmologists should meet in an Italian city, and, that its selection should be left to the Italian ophthalmological society.

It was due to Donders' efforts, who was the president at the Amsterdam meeting, that Italy succeeded in fulfilling this trust in a brilliant manner.

Quaglino, who was made chairman of the committee on preliminary work, called the sixth congress to Milan, and it began its meeting there in September 1880. There were 118 members present.

Before closing the session an invitation on the part of Cervera (Madrid) was enthusiastically accepted, and it was decided that the next session should be held at Madrid in 1884. A motion by Dr. Landolt, that in future the sessions of the periodical

international congress of ophthalmologists should be united with those of the section of ophthalmology of the international congress of the medical sciences, was laid over to be acted upon at the next session of the international congress.

This session never took place. The universal medical congress which was to meet at Copenhagen in 1883, was postponed until 1884, and this fact induced the Spanish committee not to call the session of the international congress of ophthalmologists for the same year, and to leave it to the section of ophthalmology of the Copenhagen congress to decide on the next meeting of the international congress of ophthalmologists.

The official report of the Copenhagen congress does not show, whether this question was ever taken up by this section.

Since then nothing further has been heard from the periodical international congress of ophthalmologists.

Shall it quietly disappear from the list of scientific congresses?

The ophthalmological society of Heidelberg is not of such an opinion.

This society through us makes it known, that it is our desire to be able to shake hands with all colleagues of all countries at its 25th anniversary in the second week of August 1888 at Heidelberg, and we desire to draw attention to the fact that already once before the International Congress of Ophthalmologists was aroused from a death-like trance by this society and to remind them of the resolution of the Milan congress, that the next session shall decide upon Dr. Landolt's motion, as above mentioned.

If this motion should prevail the International Congress will, though losing its individuality, live on vigorously and honorably, in another form.

The ophthalmological society which we represent, hopes the more, that its invitation will be readily accepted by all, since the Periodical International Congress of Ophthalmologists has never before met in a German city.

OTTO BECKER.—WILHELM HESS.

January 1888.

REVIEWS.

THE REFRACTION OF THE EYE. A manual for students. By Gustavus Hartridge, F.R.C.S. P. Blakiston, Son & Co., Philadelphia. Third edition. Price, \$3.

This book which in a few years has reached its third edition gives a clear and full exposé of the errors of refraction and accomodation, with practical rules for their correction. It is characteristic of the English writer that ophthalmoscopy is detailed in 16 pages, while retinoscopy occupies just double that space. It has 96 illustrations, including 4 pictures of the fundus of myopic eyes. Altogether it is a very commendable little volume.

HANDBOOK FOR YOUNG AND OLD OPTICIANS. A concise and comprehensive treatise on the theory of the optical trade and of its mechanical manipulations. An indispensable companion to all progressive co-laborers of the optical trade, containing many points heretofore unexplored and unexplained. With illustrations. By W. Bohme, optician. Published by the author, No. 119 Canal street, New Orleans, La., 1888. Price, \$2.50.

This title is almost pompous enough to frighten an ordinary reader away. However, with all its unnecessary display, it cannot materially alter the fact, that the little book is of value and will repay the reading.

It is a fact, which we note with satisfaction, that the intelligent opticians are beginning to be more than mere mechanics. This tendency should be decidedly encouraged. The more they know about the theory of the optical trade, the less will they be liable to do bad work and to practice quackery.

With all its faults, we heartily recommend this original effort of an optician, to opticians and oculists.

THE PRESCRIPTION, THERAPEUTICALLY, PHARMACEUTICALLY AND GRAMMATICALLY CONSIDERED. By Otto A. Wall, M.D., Ph.G., St. Louis, Mo. 1888. Aug. Gast Bank Note and Lithographing Company.

This is a scholarly book, worthy of a wide-spread circulation, and if our recommendation can do anything to help this circulation along, we feel that we have aided in a good cause. The necessity of such a book is obvious to anyone who will take the trouble to step into a drug store and look over a few pages of the prescriptions daily received there. Dr. Wall ought to have the thanks of the whole profession. The type is, however, too small and should be changed.

THE NURSE AND MOTHER. A manual for the guidance of monthly nurses and mothers, etc. By Walter Coles, M.D., St. Louis, Mo. 1887. J. H. Chambers & Co.

This is a very practical manual and full of valuable suggestions to those to whom it is addressed and who will be well instructed by its counsels. The doctor will allow us to draw his attention to the fact that we fail to find any mention of blenorrhœa neonatorum, its origin and prophylaxis, and *wrong* treatment. Some sound advice in this direction could, in our opinion, not fail to do a great deal of good in the hands of those who will read this book, and we feel satisfied that there will be many of them.

ALT.

THE TREATMENT OF HÆMORRHOIDS BY INJECTIONS OF CARBOLIC ACID AND OTHER SUBSTANCES. By Silas T. Yount, M.D., of Lafayette, Ind.

This little work gives some very practical hints on the treatment of hæmorrhoids by injections. It contains illustrations including one of the author's speculum and several of his methods of injecting; also a description of some cases from the author's practice. The exact procedure of the operation and errors to be avoided are clearly laid down in the treatise. In short, it is a book which the reviewer can recommend to all interested in the subject.

L. T. RIESMEYER.